MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04497

4599

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Barroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Taneytown
LENGTH OF STAY (In this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS (O)

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Taneytown X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) J. (Middle) Maurice (Last) Angell

4. DATE OF DEATH: (Month) May (Day) 19 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: October 19, 1874

9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Angell

14. MOTHER'S MAIDEN NAME: Mary Ann Kemper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: George W. Angell, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Coronary Occlusion — undetermined

(C) Arteriosclerotic heart disease — 10 yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1955 to May, 1955, that I last saw the deceased alive on May 18, 1955, and that death occurred at 11:20 A M, from the causes and on the date stated above.

SIGNATURE Robert S. Fleet M.D. M.D. ADDRESS Taneytown Md. DATE SIGNED 5/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF May 21, 1955

NAME OF CEMETERY OR CREMATORY Reformed Cemetery

LOCATION (City, town, or county) (State) Taneytown, Maryland

DATE REC'D BY LOCAL REGISTRAR May 20, 1955

REGISTRAR'S SIGNATURE Ethel M. Mehring

24. FUNERAL DIRECTOR ADDRESS C.O. Fuss & Son, Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04498

CERTIFICATE OF DEATH

1 4510 Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville X
LENGTH OF STAY (in this place) 16yr.1mo.25days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 2103-2

3. NAME OF DECEASED: (Type or Print) (First) MAY (Middle) Q, (Last) BACHTELL
4. DATE OF DEATH: (Month) May (Day) 16 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: May 10-1877
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Hose re-Knitter
10b. KIND OF BUSINESS OR INDUSTRY: Unk-
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harvey Bachtell
14. MOTHER'S MAIDEN NAME: Harriett Harbaugh
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: Unk-
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

331 X
Immediate cause (a) Cerebral Infarction — Days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral Arteriosclerosis — Years
DUE TO
(c) Chronic Nephrosclerosis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral Arteriosclerosis. — 17 years

19a. DATE OF OPERATION: 2
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3, 1955, to 5-16, 1955, that I last saw the deceased alive on 5-16, 1955, and that death occurred at 1:55 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Gertrude M. Cross, M.D. Springfield State Hospital 5-16-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 5-18-55
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Hagerstown Md
DATE REC'D BY LOCAL REGISTRAR May 17, 1955
REGISTRAR'S SIGNATURE C. Harry Tyler
24. FUNERAL DIRECTOR Eliott F Minnick & Son
ADDRESS Hag Md

VS. A15

04499

MARYLAND — **STATE DEPARTMETT OF HEALTH**

4511 CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll (Myers District) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Nr. Westminster
LENGTH OF STAY (in this place) 4 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Westminster, Md. R.D.1

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. (Myers District) COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Westminster X
STREET ADDRESS (If rural, give location) Westminster, Md. R. D. 1 1

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) V. (Last) Bish
4. DATE OF DEATH (Month) 5/23/55 (Day) (Year) 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH 7/18/1870
9. AGE last birthday 84 yrs. If under 1 year Months. Days. If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, housework
10b. KIND OF BUSINESS OR INDUSTRY Her own home
11. BIRTHPLACE (State or foreign country) Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Absolom Zepp
14. MOTHER'S MAIDEN NAME Mary Zepp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Mrs. Airy Bish Mrs Airy Bish, Westminster, Md. R. D. 1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause 422.1 (a) cardio vascular disease — about May 1945

Antecedent cause(s) (b) (Senility) — 10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION 0 none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1946, to 5-22, 19 55, that I last saw the deceased alive on 5-21, 19 55, and that death occurred at 1:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. T. Billingslea M.D. ADDRESS Westminster, Md. DATE SIGNED 5-23-55

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 5/25/55
NAME OF CEMETERY OR CREMATORY Kriders Cemetery
LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co., Md.

DATE REC'D BY LOCAL REG. 5-23-55
REGISTRAR'S SIGNATURE Harriet Miller
24. FUNERAL DIRECTOR J. M. Little & Son
ADDRESS Littlestown, Pa.
Per R. A. Little - Partner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4512

CERTIFICATE OF DEATH

04504

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 13yr1mo17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 1913 E. Fayette Street ✓

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) INGA BJORNSON

4. DATE OF DEATH: (Month) (Day) (Year) May 27 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8-13-76

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY? Unk. ✓

13. FATHER'S NAME: Anton Bjornson

14. MOTHER'S MAIDEN NAME: Catherine Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

560.4 IMMEDIATE CAUSE (A) Secondary Anemia — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Diaphragmatic hernia — INTERVAL BETWEEN ONSET AND DEATH: unknown

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis, paranoid type. — Approx. 13 yrs.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-9, 1954, to 5-27, 1955, that I last saw the deceased alive on 5-26, 1955, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt ADDRESS M. D. Springfield State Hosp. DATE SIGNED 5-27-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF June 3, 55 — NAME OF CEMETERY OR CREMATORY & LOCATION (City, town, or county) (State) University Medical School Balto. City

DATE REC'D BY LOCAL REGISTRAR June 3, 1955 — REGISTRAR'S SIGNATURE C. Harry Hall

24. FUNERAL DIRECTOR Francis A. Hemaly — ADDRESS 575 W. Biddle

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04500

4513

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): X Sykesville
LENGTH OF STAY (in this place): 16yrs.7days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown 2103-2
STREET ADDRESS (If rural give location): 34 W. Franklin ✓

3. NAME OF DECEASED: (First) MINNIE (Middle) B. (Last) BORN
4. DATE OF DEATH: (Month) MAY (Day) 3 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Aug. 12, 1896
9. AGE last birthday: 58 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Mill worker
10b. KIND OF BUSINESS OR INDUSTRY: Work -
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Mathews
14. MOTHER'S MAIDEN NAME: ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: Unk -
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
491 X Immediate cause	(a) Septicemia	2 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Bronchopneumonia	2 weeks
1025 X	DUE TO (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with syphilitic meningo-encephalitis		16yrs.+

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 1955, to 5-3, 1955, that I last saw the deceased alive on 5-3-, 1955, and that death occurred at 10:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter F. Townsend M.D. — ADDRESS: Springfield State Hosp. — DATE SIGNED: 5/4/55

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 5/11/55 — NAME OF CEMETERY OR CREMATORY: University Medical — LOCATION (City, town, or county) (State): Balto. City

DATE REC'D BY LOCAL REGISTRAR: May 11, 1955 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: Mrs Frances A Hemely — ADDRESS: 575 W Biddle

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04501

4507

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster

LENGTH OF STAY (in this place): 21 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 168 Liberty Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster

STREET ADDRESS (If rural give location): 168 Liberty Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Gertrude	Viola	Bostian	May	6	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Nov. 10, 1904	50 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Shoe Dresser	Shoe Factory	Carroll County, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Folkert	Sadie D. Ziegler

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	- - - -	213-05-1657	Stanley O. Bostian Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1707

Immediate cause (a) Carcinoma of Breast

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) with Metastasis to liver — Interval Between Onset And Death: 1 year

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 10 54	Carcinoma - Breast	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1st, 1954, to 5/6, 1955, that I last saw the deceased alive on May 6th, 1955, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Luther Bare M.D. — ADDRESS: Westminster Md — DATE SIGNED: 5/6/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 9, 1955	Krider's Cemetery	nr Westminster	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-7-55	Hamit Fuller	John R. Byers	Westminster, Md.

4514

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04502

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sykesville
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital Sykesville, Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14
STREET ADDRESS (If rural give location) 2815 Pinewood Ave

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Elizabeth (Last) Bowen

4. DATE OF DEATH: (Month) 5 (Day) 15 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 8/12/1871

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Benhoff

14. MOTHER'S MAIDEN NAME: Elena Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 446X

		Interval between onset and death
IMMEDIATE CAUSE (A)	Uremia	3 days
ANTECEDENT CAUSE(S) — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)	Chronic nephritis	months
DUE TO (C)	Generalized arteriosclerosis	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: C.B.S. with disturbance of metabolism, growth & nutrition, with senile brain disease — years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. —
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3 5, 1955, to 5 5, 1955 that I last saw the deceased alive on 5/5, 1955, and that death occurred at 5:40 P.M., from the causes and on the date stated above.
SIGNATURE Gertrude M. Gross, M.D. M. D. ADDRESS Sykesville, Md DATE SIGNED 5/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: May 18, 1955
NAME OF CEMETERY OR CREMATORY: Woodlawn
LOCATION (City, town, or county) (State): WOODLAWN MD

DATE REC'D BY LOCAL REGISTRAR: May 16, 1955
REGISTRAR'S SIGNATURE: C. Harry Weis
24. FUNERAL DIRECTOR: Wm Cook-Blight Inc
ADDRESS: 6009 Harford Rd.

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4515

Reg. Dist. No. 04593

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville - Rural
LENGTH OF STAY (In this place) 62 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Leroy (Last) Bowman

4. DATE OF DEATH: (Month) 5 (Day) 14 (Year) 1955.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: 10/1/07

9. AGE last birthday 47 yrs. (IF UNDER 1 YEAR: Months, Days) (IF UNDER 24 HRS.: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10B. KIND OF BUSINESS OR INDUSTRY: Automobiles

11. BIRTHPLACE (State or foreign country): Montgomery County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Maynard Bowman

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Peters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 62 hrs

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Alcoholism

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-12-, 1955, to 5-14-, 1955, that I last saw the deceased alive on 5-14-, 1955, and that death occurred at 9.30 A M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Springfield State Hospital DATE SIGNED 5-14-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 20, 1955	Arlington National Cem.	Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
5-16-55	[signature]	Warner E. Pumphrey	Silver Spring

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04505

4516

CERTIFICATE OF DEATH

Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: X Rural Westminster
LENGTH OF STAY (in this place): 17 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster X
STREET ADDRESS (If rural give location): R.D. 4

3. NAME OF DECEASED: (First) HANNAH (Middle) M (Last) CASE

4. DATE OF DEATH: (Month) May (Day) 24 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 24-1889

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Mehan

14. MOTHER'S MAIDEN NAME: Mary Murry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Frances C. Case R.D. 4 Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause: 434.1 (a) Coronary Thrombosis — 1/2 hour

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic Congestive Heart Failure — 3 yrs
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 19, 1954, to May 24, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 11:30 AM, from the causes and on the date stated above.

SIGNATURE Julius Chepko (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 5/26/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF May 27, 1955 — NAME OF CEMETERY OR CREMATORY New Cathedral Cem. — LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REGISTRAR 5-26-55 — REGISTRAR'S SIGNATURE Hazel Fuller

24. FUNERAL DIRECTOR H. Bankard & Son — ADDRESS Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04506

4517

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Woodbine
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural -- Woodbine
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) IDA (Middle) A. (Last) CONAWAY

4. DATE OF DEATH: (Month) (Day) (Year) 5 - 4- 1955

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 3-11-1869

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Horace L. Shipley

14. MOTHER'S MAIDEN NAME: Susanna Gillis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS. Miss Stella Shipley, Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44.1 X IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSE (S) DUE TO (B) Hypertension Arteriosclerosis — 5 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept , 1950, to May , 1955, that I last saw the deceased alive on May 4 , 1955, and that death occurred at 5:00 A M, from the causes and on the date stated above.

SIGNATURE Julius Chepko M.D. M. D. ADDRESS Westminster Md DATE SIGNED 5/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

DATE THEREOF: 5-6-1955

NAME OF CEMETERY OR CREMATORY: Ebenezer

LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR: 5-5-1955

REGISTRAR'S SIGNATURE: Robert R. Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, ADDRESS: Winfield, Maryland

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4518

CERTIFICATE OF DEATH

Reg. Dist. No. 04507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): X Sykesville

LENGTH OF STAY (in this place): 1month6days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Balt.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore ~~City~~ (12) 03X-2

STREET ADDRESS (If rural give location): 717 Dunkirk Road

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
GEORGE	HENRY	COOPER	May	17	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	2-12-77	78 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Printer	Unk -	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Cooper	Unk -

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	220-05-5393	Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Myocardial infarction — minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Coronary thrombosis — 2 days

DUE TO (c) Arteriosclerotic cardiovascular disease — years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic react. — 2½ months

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-30, 1955, to 5-17, 1955, that I last saw the deceased alive on 5-17, 1955, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Edmund Lusthaus M.D.	Springfield State Hospital	5/17/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-20-55	Parkwood	Balto Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 18, 1955	C. Harry Weir	Howard J. Kuck	5305 Harford Rd Balto 24

VS. A15

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

4519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04508

Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Henryton
LENGTH OF STAY (in this place) 19 mos, 22dys.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparrows Point 03 X - 2
STREET ADDRESS (If rural give location) 816 J Street

3. NAME OF DECEASED. (Type or Print) (First) Coleman (Middle) Vernon (Last) Cosby

4. DATE OF DEATH: (Month) May (Day) 14 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 21, 1876

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Tin Factory

11. BIRTHPLACE (State or foreign country): Schyler, Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Zack Cosby

14. MOTHER'S MAIDEN NAME: Louise Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 5 No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-10-3223

17. INFORMANT & ADDRESS: Edna Cosby - 816 J Street, Sparrows Pt., Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiac Insufficiency

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Far adv. bilateral cavitary pulmonary TB.

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-8- , 1953, to 5-14- 1955, that I last saw the deceased alive on 5-14- , 1955, and that death occurred at 5:04 P M, from the causes and on the date stated above.

SIGNATURE T. F. Vestal. M.D. ADDRESS M. D. Henryton, Maryland DATE SIGNED 5-14-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF May 19, 1955

NAME OF CEMETERY OR CREMATORY Carver Memorial Park

LOCATION (City, town, or county) (State) Laurel, Maryland

DATE REC'D BY LOCAL REGISTRAR May 18, 1955

REGISTRAR'S SIGNATURE Albert R. Swankhouse

24. FUNERAL DIRECTOR Samuel W. Sullivan Jr. ADDRESS Balto

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4520

CERTIFICATE OF DEATH

Reg. Dist. No. 04509

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 1 yr. 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Md
STREET ADDRESS (If rural give location) 3021 Wayne Ave.

3. NAME OF DECEASED: (Type or Print) (First) Alice (Middle) Reynolds (Last) Dougherty
4. DATE OF DEATH (Month) May (Day) 21 (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow
8. DATE OF BIRTH: Dec 29 1870
9. AGE last birthday 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin Reynolds
14. MOTHER'S MAIDEN NAME: Susan Kinfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S ADDRESS: Mrs Etta Ireland 3021 Wayne Av Sykesville

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332 X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSE (S) DUE TO (B) Cerebral Arteriosclerosis — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 19, 1954 to May 21, 1955, that I last saw the deceased alive on May 21, 1955, and that death occurred at 6:30 P.M., from the causes and on the date stated above.
SIGNATURE W W Weston MD ADDRESS Sykesville Md DATE SIGNED May 21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 5/23/55 — NAME OF CEMETERY OR CREMATORY Forest Lawn Cem. — LOCATION (City, town, or county) (State) Norfolk, Va

DATE REC'D BY LOCAL REGISTRAR 5-23-55 — REGISTRAR'S SIGNATURE Asa Hedrick — 24. FUNERAL DIRECTOR Wm. J. Dickens & Sons — ADDRESS Balto Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 045110

4521

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfiled State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 12, Md. 3A1.4
STREET ADDRESS (If rural give location) 353 Evesham Avenue

3. NAME OF DECEASED: (Type or Print) (First) Rhoda (Middle) Miriam (Last) Dietz

4. DATE OF DEATH: (Month) 5 (Day) 8 (Year) 19 55

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 9 - 27 - 1882
9. AGE last birthday 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Caleb J. Cast
14. MOTHER'S MAIDEN NAME: Marian A. Kirlle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk
17. INFORMANT & ADDRESS: Burnis E. Dietz, Box 129 RFD #1, Joppa, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260X
IMMEDIATE CAUSE (A) Cerebral hemorrhage — 25 days
ANTECEDENT CAUSE (B) DUE TO Generalized arteriosclerosis — years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Diabetes mellitus — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile psychotic reactions — years

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12- , 1955, to 5-7- , 1955, that I last saw the deceased alive on 5 - 7 - 1955, and that death occurred at 7.05 AM, from the causes and on the date stated above.
SIGNATURE Edmund Lustman
ADDRESS M. D. Springfield State Hospital
DATE SIGNED 5-8-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 5/10/55
NAME OF CEMETERY OR CREMATORY Mt Olivet
LOCATION (City, town, or county) (State) Randallstown, Md.

DATE REC'D BY LOCAL REGISTRAR May 8, 1955
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Leonard F. Ruck
ADDRESS 5305 Harford Rd.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04511

4522

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: X Henryton
MARYLAND LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: A. A. Co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 02-10
STREET ADDRESS (If rural give location): 78 Pleasant Street ✓

3. NAME OF DECEASED: (First) John (Middle) Wesley (Last) Diggs
4. DATE OF DEATH: (Month) 5 (Day) 31 (Year) 19 55
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 11-2-22
9. AGE last birthday: 32 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Charlie Diggs
14. MOTHER'S MAIDEN NAME: Elizabeth Bailey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Mary Duckett - 3 Pleasant Court

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) 002X Cerebral Hemorrhage

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Far advanced active pulmonary tuberculosis

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 31, 1955, to May 31, 1955, that I last saw the deceased alive on May 31, 1955, and that death occurred at 7:15 p.m. from the causes and on the date stated above.
SIGNATURE (Degree or title): T. F. Leodal M. D
ADDRESS: Henryton State Hospital
DATE SIGNED: 5-31-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: June 3, 1955
NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery
LOCATION (City, town, or county) (State): Annapolis, Maryland
DATE REC'D BY LOCAL REGISTRAR: May 31, '55
REGISTRAR'S SIGNATURE: Albert R. Brantham
24. FUNERAL DIRECTOR ADDRESS: William Reese--108 W. Washington Street Annapolis, Maryland

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04512

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4523

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyndale
LENGTH OF STAY (in this place) 1yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brunswick Md
STREET ADDRESS (If rural give location) 15 X. 2

3. NAME OF DECEASED (Type or Print): (First) Gladys (Middle) Mary (Last) Durall

4. DATE OF DEATH: (Month) May (Day) 4 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug 29-1893

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10B. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Montgomery Co

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Mills

14. MOTHER'S MAIDEN NAME: Ida Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Thomas Durall

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hard Arterio Sclerosis — 5 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 29, 1947, to May 4, 1955, that I last saw the deceased alive on May 4, 1955 and that death occurred at 11-55 A.M., from the causes and on the date stated above.

SIGNATURE M M Martin MD — ADDRESS Lyndale Md — DATE SIGNED May 5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF May 7/55 — NAME OF CEMETERY OR CREMATORY Redland Cem — LOCATION (City, town, or county) Redland Md — (State)

DATE REC'D BY LOCAL REGISTRAR May 5, 1955 — REGISTRAR'S SIGNATURE C Harry Eiler

24. FUNERAL DIRECTOR Roy W Barber — ADDRESS Taylorsville Md

4524

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04513 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): X
LENGTH OF STAY (in this place): 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mount Airy, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Mount Airy X
STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) NEELY (Last) GRABILL

4. DATE OF DEATH: (Month) May (Day) 4 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 7-2-1910

9. AGE last birthday: 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William B. Neely

14. MOTHER'S MAIDEN NAME: Emma Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Robt. Hudgins, Garrett Pk. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

E70.3

Immediate cause (a) Barbiturate poisoning — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY home

21c. (City or town) Mount Airy **(County)** Carroll **(State)** Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY May 4, 1955 A. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Ingested overdose barbiturate

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE R. H. Fisher M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 5/4/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF 5-6-1955

NAME OF CEMETERY Pine Grove

LOCATION (City, town, or county) (State) Mt. Airy, Maryland

DATE REC'D BY LOCAL REG. 5-5-1955

REGISTRAR'S SIGNATURE Robert R. Hewitt

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04514

4525

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, Md.
LENGTH OF STAY (in this place) 2 Yr. 6 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 W 1.4
STREET ADDRESS (If rural give location) 218 S. Castle St. √

3. NAME OF DECEASED: (Type or Print) (First) (Annie) Anna (Middle) Marie (Last) Hoey

4. DATE OF DEATH: (Month) May (Day) 8 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Nov. 5-1884
9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months 6 Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady
10B. KIND OF BUSINESS OR INDUSTRY: Dept. store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Hoey Sr.
14. MOTHER'S MAIDEN NAME: Bridgett ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. ? ?
17. INFORMANT & ADDRESS: Edmund L. Craig 2204½ Mt.Royal A

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) General Arteriosclerosis — 15 Yrs.
(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 7, 1952 to May 8, 1955 that I last saw the deceased alive on May 7, 1955, and that death occurred at 5-30A M, from the causes and on the date stated above.

SIGNATURE M.D. M. Wastin M.D. ADDRESS Sykesville Md. DATE SIGNED May 8-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 5/11/55
NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR 5-9-55
REGISTRAR'S SIGNATURE R. C. Weeks
24. FUNERAL DIRECTOR John A. Moran 3000 E. Baltimore ADDRESS ST

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04515

CERTIFICATE OF DEATH

4526 Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor; LENGTH OF STAY (In this place) 4 years; HOSPITAL OR INSTITUTION, OR STREET ADDRESS (If rural give location) Rural Hawks Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor, Rural; STREET ADDRESS (If rural give location) Hawks Hill

3. NAME OF DECEASED: (Type or Print) (First) MARGARET (Middle) JANE (Last) HYDE

4. DATE OF DEATH: (Month) May (Day) 2 (Year) 1955

5. SEX: female; 6. COLOR OR RACE: white; 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married; 8. DATE OF BIRTH: Oct 20-1892; 9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife; 10b. KIND OF BUSINESS OR INDUSTRY: at home; 11. BIRTHPLACE (State or foreign country): Maryland; 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Wagner; 14. MOTHER'S MAIDEN NAME: Callie Horton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If yes: (If Yes, give war or dates of service) no; 16. SOCIAL SECURITY NO.: none; 17. INFORMANT & ADDRESS: R. E. Hyde, New Windsor, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Arteriosclerosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral hemorrhage

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-18, 1955, to 4-30, 1955, that I last saw the deceased alive on 4-30, 1955, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE J. H. Legg (Degree or title) ADDRESS Union Bridge, Md DATE SIGNED 5-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 5/4/55; NAME OF CEMETERY OR CREMATORY Winters Cem.; LOCATION (City, town, or county) Carroll County, Md. (State)

DATE REC'D BY LOCAL REGISTRAR May 3-1955; REGISTRAR'S SIGNATURE Cecil LaBerdict

24. FUNERAL DIRECTOR H. O. Hartzler & Sons ADDRESS New Windsor, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

4527

04516

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Mt. Airy | LENGTH OF STAY (in this place) 2 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If rural, give location) Route 3.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mount Airy X
STREET ADDRESS (If rural, give location) North Main /

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) Ellen (Last) Kolb
4. DATE OF DEATH: (Month) May (Day) 13 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 6 1881
9. AGE last birthday: 74 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Abdiel Garber
14. MOTHER'S MAIDEN NAME: Sarah Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 215-03-6118
17. INFORMANT AND ADDRESS: Ghaile Kolb, Mt. Airy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
Immediate cause (a) Coronary Thrombosis — 35 minutes

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arteriosclerotic Heart Disease — 2 years
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1953, to May, 1955, that I last saw the deceased alive on May 13, 1955, and that death occurred at 11 15 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

W B Culwell, M.D. | Mount Airy | May 13, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: May 16/1955 | NAME OF CEMETERY OR CREMATORY: Pine Grove | LOCATION (City, town, or county) (State): Mt Airy Md.

DATE REC'D BY LOCAL REG.: May 15 1955 | REGISTRAR'S SIGNATURE: Robert A. Hewitt

24. FUNERAL DIRECTOR: C.M. Walt L. | ADDRESS: Winfield Md. R2 N. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04517

4528

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, Md.
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural give location) 39 West George Street 1

3. NAME OF DECEASED: (Type or Print) (First) Francis (Middle) John (Last) Lambert

4. DATE OF DEATH: (Month) 5 (Day) 22 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH. 2-22-66

9. AGE last birthday 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10B. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Lambert

14. MOTHER'S MAIDEN NAME: Julia Flinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-18-0345

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (B) DUE TO (B) Coronary Thrombosis — 6 hours

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic cardiovascular disease — years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with senile brain disease — years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-10-1955, to 5-22-, 1955, that I last saw the deceased alive on May 22, 1955, and that death occurred at 1.50 PM, from the causes and on the date stated above.

SIGNATURE Edmund Lustbader M.D. ADDRESS Springfield State Hospital DATE SIGNED May 22, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 5-25-55 — NAME OF CEMETERY OR ~~CREMATORY~~ Beaver Dam — LOCATION (City, town, or county) (State) Frederick Co., Md.

DATE REC'D BY LOCAL REGISTRAR May 23, 1955 — REGISTRAR'S SIGNATURE C. Harry Zeller — 24. FUNERAL DIRECTOR C.D. Haifley & Son — ADDRESS New Windsor Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4529

CERTIFICATE OF DEATH

04518

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Littlestown Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) Westminster RD #1

3. NAME OF DECEASED: (Type or Print) (First) REUBEN (Middle) HENRY (Last) MORNINGSTAR

4. DATE OF DEATH: (Month) May (Day) 6 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 29 1893

9. AGE last birthday: 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Rubber factory

10b. KIND OF BUSINESS OR INDUSTRY: Cambridge Rubber Co

11. BIRTHPLACE (State or foreign country): Fred. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Clayton Morningstar

14. MOTHER'S MAIDEN NAME: Annie Bohn

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 216-03-9174

17. INFORMANT & ADDRESS: Mrs R.H. Morningstar, Westminster Md Rd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X

Immediate cause (a) Carcinoma Pancreas with — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized metastases. — DUE TO

(c)

Interval Between Onset And Death: 7 months

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/27, 1955 to 5/6, 1955, that I last saw the deceased alive on 5/6, 1955, and that death occurred at 7:50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Allen Morton M.D. ADDRESS Westminster Md DATE SIGNED 5/9/55

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial — **DATE THEREOF** 5/9/55 — **NAME OF CEMETERY OR CREMATORY** Meadow Branch Cem. — **LOCATION** (City, town, or county) (State) Rural, Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR 5-7-55 — **REGISTRAR'S SIGNATURE** Hamit Miller

24. FUNERAL DIRECTOR J.S. Myers Jr. — **ADDRESS** Westminster Md

4530

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04519 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Westminster
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural--Westminster
STREET ADDRESS (If rural, give location) R.D. # 5

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	PLEASANT	NINER	May 11 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	white	married	10-31-1887	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Maryland	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Joseph Shipley	Alice Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Ernest R. Niner, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 822X Crushing injury to Chest and Abdomen — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg), etc. INJURY	21c. (City or town)	(County)	(State)
	County Road	Nr Westminster	Carroll	Md

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR?
5 11 55 12:30 P.M.		Upset Tractor pinned her under it

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Thomas M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 5/11/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	5-14-1955	Deer Park	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
5-13-55	Lamont Miller	C. M. Waltz, Winfield, Maryland

4531

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04520 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 10 mos, 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Montgomery
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN RFD, Germantown
STREET ADDRESS (If rural, give location) 15A-2

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARVEY	EDWARD	POOLE	5	9	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	9/15/96	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	State Roads	Montgomery County, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Philmore Poole	Margaret Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes WI	212-14-5997	Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Subdural Hematoma	18 hours
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Fracture of Skull	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Alcoholism Psychotic depressive reaction — Years, Months

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospital	21c. (City or town) Sykesville	(County) Carroll	(State) Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
5	8	55	10:30 A.M.			Patient fell from bed to floor

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Moore M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 5/9/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 12, 1955	Salem	Cedar Grove, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 11, 1955	C. Harry Zimmerman	Olin L. Molesworth	Damascus, Md.

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4532 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04521

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item Film 181 5-5-55 et

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 5 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springf. State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18
STREET ADDRESS (If rural give location) 619 E. 35th Str.

3. NAME OF DECEASED: (First) Frances (Middle) D. (Last) Price

4. DATE OF DEATH: (Month) 5 (Day) 1 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

8. DATE OF BIRTH: 1-22-80

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: /

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Reynolds

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
44.3X IMMEDIATE CAUSE	(A) Cardio-Vascular Accident	2 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Hypertensive Arteriosclerotic Disease DUE TO	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 2 S C Circulatory Disturbance C Psychotic Reaction

19A. DATE OF OPERATION: /

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-9, 1954, to 5-1, 1955, that I last saw the deceased alive on 5-1, 1955, and that death occurred at 10:45 a M, from the causes and on the date stated above.

SIGNATURE Gerhard Sonnenfeld M.D. ADDRESS Springfield State Hospital & Sykesville Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 5/4/55

NAME OF CEMETERY OR CREMATORY Knoxville

LOCATION (City, town, or county) (State) Knoxville, Md.

DATE REC'D BY LOCAL REGISTRAR 5-2-55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Wm. J. Pickney & Sons ADDRESS Baltimore

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04522

4598

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
LENGTH OF STAY (in this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Carroll St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural, give location) 60 Carroll 1

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) A (Last) REESE

4. DATE OF DEATH: (Month) MAY (Day) 23 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 19, 1861

9. AGE last birthday: 93 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Lowe

14. MOTHER'S MAIDEN NAME: Catherine Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service) None

17. INFORMANT & ADDRESS: Emma Rue Berwager 60 Carroll St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Myocardial degeneration DUE TO Anemia	2 yrs 3 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Carcinoma of rectum DUE TO	4 yrs +
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death: Senility

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. [illegible], 1955 to May 23, 1955, that I last saw the deceased alive on May 23, 1955, and that death occurred at 6:45 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
J. Reese Wilkens M.D. Westminster, Md 5-25-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 26, 1955
NAME OF CEMETERY OR CREMATORY: Sandymount Cemetery
LOCATION (City, town, or county) (State): Sandymount Md.

DATE REC'D BY LOCAL REG. 5-26-55
REGISTRAR'S SIGNATURE: Hazel Mills
24. FUNERAL DIRECTOR ADDRESS: Bankard Bros Westminster, Md.

4533 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04523

CERTIFICATE OF DEATH

Reg. Dist. No. 14-10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodsboro
STREET ADDRESS (If rural give location) 10 X-2

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) MURRAY (Last) REISLER

4. DATE OF DEATH: (Month) MAY (Day) 26 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH:

9. AGE last birthday: 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Loyd Reisler

14. MOTHER'S MAIDEN NAME: Jennie Breighner

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Bronchiogenic carcinoma — DUE TO — years ?

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

162 X

11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Senile Brain Disease, psychotic reaction — Approx. 4½ years

19a. DATE OF OPERATION: 0 — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-14, 1955, to 5-26, 1955, that I last saw the deceased alive on 5-25, 1955, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Svrmingfield M.D. — ADDRESS Springfield State Hospital — DATE SIGNED 5/26/55.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF May 31-1955 — NAME OF CEMETERY OR CREMATORY Rocky Hill — LOCATION (City, town, or county) nr, Woodsboro — (State) MD

DATE REC'D BY LOCAL REGISTRAR May 30, 1955 — REGISTRAR'S SIGNATURE L G Powell C. Harry Myers

24. FUNERAL DIRECTOR G.C.Barton — ADDRESS Walkersville Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04524

4534

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Rural Westminster
LENGTH OF STAY (in this place): 78 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Westfield Manor

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster RD #5
STREET ADDRESS (If rural give location): Westfield Manor

3. NAME OF DECEASED: (First) MARY (Middle) ANNA (Last) RICKELL
DATE OF DEATH: (Month) May (Day) 1 (Year) 1955

4. SEX: F
5. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: Dec 15 1876
9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Richter
14. MOTHER'S MAIDEN NAME: Rebecca E. Stephen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Mrs Frank S. Penn, Westminster and RD #5

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (420.1): (a) Coronary Thrombosis — Interval Between Onset And Death: Several hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b): Hypertension, Coronary Sclerosis — Several yrs
DUE TO (c): Myocardial degeneration + Cerebral involvement

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov ..., 1954, to May 1 ..., 1955, that I last saw the deceased alive on May 1 ..., 1955, and that death occurred at 7:50 AM; from the causes and on the date stated above.
SIGNATURE (Degree or title): Wylene Speicher — ADDRESS: Westminster Md — DATE SIGNED: 5-2-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 4 55
NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
LOCATION (City, town, or county) (State): Westminster Md.
DATE REC'D BY LOCAL REGISTRAR: 5-2-55
REGISTRAR'S SIGNATURE: Harriet Miller
24. FUNERAL DIRECTOR: J. S. Myers Jr. — ADDRESS: Westminster Md.

VS. A15

MARYLAND 4535

04525

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, FilmG181 5-23-55 et Items 6,9,13 FilmG182 6-7-55 et

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville, Maryland; LENGTH OF STAY (In this place) 8yrs. 1mo.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balto.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville 28; STREET ADDRESS Daughters of the Eucharist / Maiden Choice Lane

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Daisy	Riley	5	12	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	6-26-85 June 26, 1869	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Balto., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Luke Collins Riley

14. MOTHER'S MAIDEN NAME: Mary Jane Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk (If year, give war or dates of service) ----

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary occlusion — Interval between onset and death: 1 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paranoid condition

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
----	-----	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
----	-----	-----		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
----			m.		-----

22. I hereby certify that I attended the deceased from 4-9- ., 19.52., to 5-12-., 19..55, that I last saw the deceased alive on 5-11- ....., 19..55, and that death occurred at 3:30 A.m., from the causes and on the date stated above.

SIGNATURE Ilse Kamm, M.D. (Degree or title) ADDRESS Springfield State Hosp., Sykesville, Md. DATE SIGNED 5-12-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5/14/55	Loudon Park	Baltimore	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 12, 1955	C. Harry Weir	Easton Sons	Catonsville

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04526

4536

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural - Sykesville
LENGTH OF STAY (in this place): 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-24 SW 14
STREET ADDRESS (If rural give location): 3212 Foster Avenue ✓

3. NAME OF DECEASED: (First) JOSEPH (Middle) (Last) ROTH
4. DATE OF DEATH: (Month) 5 (Day) 5 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 10/19/77
9. AGE last birthday: 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY: POOLE ENG. CO.
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Roth
14. MOTHER'S MAIDEN NAME: KUNIGUNDA VASOLD.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Cerebral Hemorrhage — Interval Between Onset And Death: since 4/16

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Generalized arteriosclerosis — unknown

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with senile brain disease, with psychotic reaction — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/16/55, 19.., to 5/5/, 1955, that I last saw the deceased alive on 5/4, 19 55, and that death occurred at 7:15 A.M. DST from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Walter H Tonnemacher M.D. Sykesville, Maryland 5/5/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF 5-9-55 — NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. — LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.

DATE REC'D BY LOCAL REGISTRAR 5-6-55 — REGISTRAR'S SIGNATURE a w Hedrick — 24. FUNERAL DIRECTOR Charles S. Zeller — ADDRESS 901 S. CONKLING ST BALTO., 24, MD.

JST

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04527

4537

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 9month27days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore City (29) 3 Vol 4
STREET ADDRESS (If rural give location) 4800 Coleherne Road

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) K. (Last) SINGER

4. DATE OF DEATH: (Month) May (Day) 30 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH. 4-13-84

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days. IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Work

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME. Henry Singer

14. MOTHER'S MAIDEN NAME: Katherine [illegible] Ortell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

521 X
IMMEDIATE CAUSE (A) Lung abscess — INTERVAL BETWEEN ONSET AND DEATH: one week

ANTECEDENT CAUSE (S) DUE TO (B) Bronchopneumonia — *

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 002 X
DUE TO (C) Chronic pulmonary Tuberculosis — 1 year +

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease, with psychotic react. 5 years

19A. DATE OF OPERATION: 7

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3- , 1955, to 5-30 , 1955, that I last saw the deceased alive on 5-29 , 1955, and that death occurred at 4:40A M, from the causes and on the date stated above.

SIGNATURE Walter H. Smeudeker M.D ADDRESS Springfield State Hosp. DATE SIGNED 5-30-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 6/3/55

NAME OF CEMETERY OR CREMATORY: First United Evangelical Cem.

LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REGISTRAR: 5-31-55

REGISTRAR'S SIGNATURE: [signature] 55

24. FUNERAL DIRECTOR: Wm. J. Tuckerman & Sons

ADDRESS: Balto 17 Md

4538

04528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (In this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore 13
STREET ADDRESS (If rural, give location) 3332 Lyndale Avenue

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALICE EDLINGER SMITH	May 11 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	12-14-69	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Edlinger	Mack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	Mack.	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Uremia DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Chronic & acute suppurative cystitis DUE TO	Several months
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome with senility, with psychotic reaction. — 4 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) (County) (State) 3332 Lyndale Ave., Baltimore 13, Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Prior to 5-6-55 M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR? Fell while attempting to get out of bed.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Moran M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 5/12/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-14-55	Baltimore	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 12, 1955	C. Harry Weir	Howard J. Ruck	5305 Harford Rd.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04529

4539

CERTIFICATE OF DEATH

Reg. Dist. No. 77

Item 8, FilmCl81 5-9-55 et

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X Hampstead | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead X
STREET ADDRESS (If rural give location) ✓ 1

3. NAME OF DECEASED: (Type or Print) (First) LOTTIE (Middle) B (Last) STINE

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 19 55

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced | 8. DATE OF BIRTH: Jan 28 1879

9. AGE last birthday: 76 yrs. | If UNDER 1 YEAR: Months, Days | If UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY: Nick. | 11. BIRTHPLACE (State or foreign country): Penna | 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry H Stine | 14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: No | 17. INFORMANT & ADDRESS: Mrs Eugene Fourhman, Hampstead Md

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) Coronary Thrombosis	1 hr.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Hypertensive C.V. Disease	15 yrs.
	(c) DUE TO	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Old Cerebral Hemiplegia	3 yrs

19a. DATE OF OPERATION: 0 | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19 55, to May 19 55, that I last saw the deceased alive on April 30, 19 55, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M. C. Satterfield, M.D. | ADDRESS Hampstead Md | DATE SIGNED 5-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF May 4 55 | NAME OF CEMETERY OR CREMATORY Stultz | LOCATION (City, town, or county) York Co (State) Pa

DATE REC'D BY LOCAL REGISTRAR 5/4/55 | REGISTRAR'S SIGNATURE Henry F Reed | 24. FUNERAL DIRECTOR Edw Clipton | ADDRESS Hampstead Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04550

4540

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
LENGTH OF STAY in this place 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Alverda (Last) Welsh

4. DATE OF DEATH: (Month) May (Day) 10 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 24, 1875

9. AGE last birthday: 80 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Augustus Harding

14. MOTHER'S MAIDEN NAME: Luella Dorsey THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: Mrs. Ethel Haines, Woodbine, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Arteriosclerotic Heart Disease — Interval between onset and death: over 10 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis — Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1955, to May 10, 1955, that I last saw the deceased alive on May 10, 1955, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.B. Culwell	M.D	Mt. Airy Md.	May 10, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-13-1955	Morgan Chapel	Carroll Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 12 1955	Robert P. Hewitt	C. M. Wallis	Winfield Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING